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Legal Protection for Healthcare Workers Against Workplace Violence in Indonesian Hospital Governance

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Abstract

Workplace violence against healthcare workers remains a persistent risk in health facilities, negatively impacting occupational safety, service quality, and institutional accountability. This research analyzes the scope of legal protection for healthcare workers in cases of violence, using one of the cases in public controversy as a contextual entry point to discuss the full spectrum of violence. The study aims to map the legal framework governing healthcare workers' protection, examine hospitals' responsibilities in prevention and response, and formulate feasible protection mechanisms and operational policy recommendations. Utilizing a normative-juridical approach with statutory and conceptual frameworks, the analysis indicates that Law Number 17 of 2023 concerning health explicitly recognizes healthcare workers' rights to legal protection and occupational safety. However, significant implementation gaps persist at the institutional level, including weak reporting channels, inconsistent standard operating procedures, and insufficient anti-retaliation safeguards. The study concludes that effective protection requires translating statutory rights into robust operational hospital governance through zero-tolerance policies, integrated incident reporting and investigation systems, and comprehensive recovery support for victims.

Keywords

Healthcare Workers, Hospital Governance, Indonesia, Legal Protection, Workplace Violence.

1. Introduction

Violence against healthcare workers is a major concern in healthcare governance because it undermines occupational safety, service quality, and human dignity. It includes physical assault, verbal abuse, threats, intimidation, bullying, sexual harassment, and discrimination that can harm workers psychologically and professionally. International organizations such as the World Health Organization, International Labour Organization, International Council of Nurses, and Public Services International define workplace violence as abuse, threats, or assaults related to healthcare work that jeopardize workers' safety and well-being. These frameworks emphasize that violence is not an inevitable occupational risk and requires prevention, reporting systems, institutional accountability, and legal protection mechanisms (Shepherd, 1994; World Health Organization, 2002; Rossi et al., 2023).

The urgency of workplace violence in healthcare is evident from extensive evidence showing that healthcare settings remain among the most vulnerable workplaces globally. Systematic reviews and meta-analyses report high rates of physical and verbal violence against healthcare professionals, particularly nurses and emergency department staff (Liu et al., 2019; Recsky et al., 2023; Önal et al., 2023). Studies have further demonstrated that workplace violence adversely affects healthcare workers' mental health, increases burnout, lowers job satisfaction and quality of life, and contributes to reduced service quality and higher rates of medical errors (Havaei et al., 2020; Agbornu et al., 2022; Abubhasheesh et al., 2024). Organizational factors, including understaffing, overtime, night shifts, high turnover, and weak management systems, also elevate the risk of violence in healthcare facilities (Giusti et al., 2024). The problem is particularly pronounced in emergency departments and intensive care units, where emotionally charged interactions frequently occur (Benning et al., 2024; Berger et al., 2024).

Contemporary literature increasingly highlights structural violence within healthcare institutions as a significant form of workplace harm. Structural violence refers to discriminatory institutional practices that undermine workers' dignity, autonomy, and equal treatment, such as biased recruitment, discriminatory regulations, and organizational cultures that discourage reporting. Unlike physical assaults, non-physical violence can generate lasting psychological effects, including chronic insecurity and emotional exhaustion (Beech & Leather, 2006). Recent studies by Schulz-Quach et al. (2024) and Abreu et al. (2026) further indicate that many healthcare institutions still lack independent reporting systems, victim protection mechanisms, and comprehensive prevention protocols, contributing to substantial underreporting of workplace violence incidents and weakening efforts to ensure safe working environments.

The Indonesian context demonstrates that workplace violence against healthcare workers is not merely a theoretical concern but an empirical reality. Survey-based research conducted in Yogyakarta confirmed that healthcare workers frequently experience verbal abuse, threats, and psychological intimidation in healthcare facilities, particularly in high-pressure service units (Pidada & Wahab, 2024). Similar findings were reported in studies involving emergency nurses in Indonesia, where violence was shown to affect emotional stability and professional performance (Öztaş et al., 2023). Despite the increasing prevalence of such incidents, healthcare workers often face barriers to reporting due to fear of retaliation, organizational hierarchy, and the absence of secure complaint mechanisms.

The enactment of Law Number 17 of 2023 on health strengthened legal guarantees for healthcare workers' rights to occupational safety and protection when performing their duties according to professional standards. However, implementation remains inconsistent, as many hospitals have not established

effective policies, reporting systems, or accountability mechanisms. This gap between legal norms and practice became evident during the 2024 Medistra Hospital controversy, where allegations of discriminatory recruitment practices related to the use of hijab by healthcare worker applicants generated widespread public debate. Reports by CNN Indonesia (2022), detikNews (2024), and Beritasatu.com (2024) indicate that healthcare worker vulnerability may stem not only from patients or visitors but also from internal managerial policies and institutional practices.

Based on this background, existing studies primarily examine workplace violence from medical and public health perspectives, focusing on its prevalence, impacts, and prevention. Few studies analyze workplace violence against healthcare workers through the lens of legal protection and hospital governance under Indonesia's 2023 Health Law, particularly by integrating physical, verbal, psychological, and structural forms of violence into a single legal framework. This study addresses that gap by mapping the legal protection framework for healthcare workers under the 2023 Health Law, extending the analysis to include structural and discriminatory institutional practices, and developing practical recommendations for hospital governance using the Medistra Hospital controversy as a contextual case. This study aims to assess the effectiveness of legal protections against workplace violence and evaluate how hospitals implement these obligations within governance and occupational safety systems.

2. Methods

This research is fundamentally designed using a normative juridical research methodology (normative legal research). This doctrinal method essentially places law as a system of norms (rules, principles, and regulations) and methodically examines it through an analysis of the systematics of legislation, various relevant doctrines or legal theory concepts, and utilizes sharp legal reasoning logic to draw prescriptive conclusions (Ibrahim, 2006; Marzuki, 2017). This methodological design was chosen with careful consideration, given that the main focus of this article is to precisely identify, map, and critically analyze the anatomy of legal protection for healthcare workers facing various cases of violence. This analytical focus is ultimately more relevant, targeted, and accurately answered through the mapping of norms, the process of systematic regulatory interpretation, and the construction of solid legal arguments, rather than through the process of measuring statistical figures like quantitative research in the empirical field.

This normative legal research relies on two complementary main analytical approaches. First, the statute approach, which is specifically focused on peeling, dissecting, and dogmatically examining imperative norms governing the delineation of rights and legal protection guarantees for healthcare workers, with particular reference to the body of Law Number 17 of 2023 concerning Health. Second, utilizing a conceptual approach, deployed to explore and clarify the boundaries of terminology and concepts regarding "violence against healthcare workers" within the macro spectrum of workplace violence, including the integration of non-physical violence, psychological aggression, and structural oppression dimensions relevant to the dynamics of power relations at work.

The technique of collecting and acquiring data in this research is realized purely through an in-depth library research method. The search stages are focused on inventorying three clusters of legal material instruments: primary legal materials consisting of authoritative texts of hierarchically relevant legislation (the 2023 Health Law and the Criminal Code). Secondary legal materials extracted from various scientific literature, textbooks, monographs, and national and international journal publications that substantially examine the problem of workplace violence in the healthcare sector, and tertiary legal materials in the form of glossaries, legal dictionaries, and medicolegal encyclopedias. At the final analysis point, the entire

collection of data or legal materials that have been selected using the selective sampling of legal materials method will be processed, unraveled, and evaluated qualitatively and prescriptively. Drawing conclusions will rely on grammatical interpretation methods to interpret phrases in the law literally, as well as systematic interpretation to connect and ensure rational coherence between existing norms to formulate implementable managerial governance recommendations (Soekanto 2007).

3. Results and Discussion

3.1. Legal Protection of Patient Data in Indonesia

The primary findings identified during this fundamental concept mapping stage firmly indicate that the discourse regarding the terminology “violence against healthcare workers” should be holistically constructed and understood as a spectrum of deviant behavior and toxic work environment conditions that tangibly destroy the foundation of work security and comfort (Ilikannu et al., 2025). As emphasized by Beech and Leather (2006), this broad spectrum of violence, in its various empirical manifestations in the field, includes: first, physical violence in the form of brutal aggression such as hitting, choking, throwing objects, to physical assaults using weapons that potentially fatally injure the bodily integrity of medical personnel; second, verbal violence which is often considered trivial but is deadly, manifesting in the form of harsh swearing, insults, racist slurs, and verbal harassment; third, direct threats or veiled intimidation designed to instill fear; fourth, bullying/mobbing practices and sexual harassment in the work area; and fifth, equally destructive, are non-physical violence, psychological violence, and structural violence that can systematically thrive through flawed institutional practices and hospital organizational regulations. These ultimately trigger tremendous mental pressure, create an atmosphere of chronic fear, and exploit the vulnerabilities of healthcare workers within the labyrinth of hierarchical work relations.

The doctrinal framework of international guidelines published by collaborating institutions such as the World Health Organization (WHO) and the comprehensive joint program of ILO/ICN/WHO/PSI, unanimously positions the issue of violence in healthcare facility sectors not merely as an anomaly of individual behavior, but purely as a serious problem within the domain of Occupational Health and Safety (OHS). This modern paradigm dictates that the problem of violence requires the application of preventive management policies and handling procedures that are truly comprehensive, radical, structured, and can no longer rely solely on amicable settlements or mere reactive incidental responses moments after a tragedy of violence has already erupted (World Health Organization, 2002).

Shifting to the perspective of domestic literature reviews in Indonesia, the results of various academic studies and empirical observations convincingly confirm a dark reality that workplace violence incidents targeting groups of healthcare workers are a recurrent phenomenon, akin to an unbroken cycle, delivering highly significant and widespread destructive power (Tian et al., 2020; Ajuwa et al., 2024). Ironically, the heaviest risk burden of this violence cycle is unfairly borne by the professional group of nurses and dedicated healthcare workers stationed right at the frontline of emergency services and first-contact public interactions. A crucial reference, namely a massive survey study aimed at representatives of public healthcare workers in the Yogyakarta province, nakedly demonstrates that the bitter experience of being a victim of violence in the hospital environment has been recognized as an exceedingly serious issue, massively undermining the emotional well-being and stability of workers and degrading their sense of security during service (Pidada & Wahab, 2024).

Other sociological research specifically examining and dissecting the traumatic experiences of nurses in the Emergency Departments (ED) of hospitals in Indonesia reaffirms a concerning conclusion. The study found that exposure to verbal violence and bursts of physical threats has gradually transformed into a “normal” part of their daily work experience. This terrifying condition naturally forces nurses to develop various individual coping mechanisms to survive amidst the harsh pressures of their work shifts. However, this phenomenon of forced adaptation harbors a very dangerous sociological time bomb; passive acceptance of violence has a high potential to culminate in the normalization of violence. This normalization process will thrive boundlessly if hospital institutions remain apathetic by failing to provide transparent, easily accessible incident reporting system infrastructures, and failing to provide adequate psychosocial support for their workers. Studies by O’Brien et al. (2024) and Lyver et al. (2024), relying on questionnaire-based analysis from thousands of respondents, consistently find that the high prevalence of violence in the corridors of emergency departments is an emergency issue in itself, desperately requiring the formulation of strategic prevention policies and the initiation of structural organizational intervention programs from the top management level that are far stronger and more binding.

An in-depth analysis of the destructive impacts caused by exposure to violence against healthcare workers shows that the chain of detrimental effects does not stop or remain limited solely to the suffering of individual victims (such as prolonged trauma symptoms, depression, acute stress, extreme physical and emotional exhaustion or burnout, or the freefall of job satisfaction indices). Havaei et al. (2020) demonstrated that workplace violence significantly contributes to burnout and negative health outcomes among healthcare workers. Instead of being isolated, the destructive effects of such violence spread rapidly like a virus, penetrating and damaging the performance order at the organizational operational level and the macro healthcare service governance system. The cascading consequences include: surging rates of worker absenteeism for medical and non-medical reasons, plummeting hospital ability to retain competent staff (low retention rates and high turnover of healthcare workers resigning due to toxic work environments), deteriorating quality of coordination and clinical communication among medical teams working under the shadow of fear, and the most life-threatening impact to the general public is the increased probability of healthcare workers making fatal errors in providing service interventions and medication (medical errors).

The World Health Organization (2002), in its reports has issued a stern warning that the epidemic of workplace violence can absolutely decrease the quality standards and the smooth continuity of public healthcare systems drastically, considering the reality that the patient healing process cannot possibly be maximally achieved if the healthcare workers themselves are forced to work under conditions full of emotional pressure, exhaustion, and feeling completely unsafe. Based on these logical rationales, all forms of violent threats must be positioned at the highest category as part of occupational hazards. This dangerous risk absolutely requires the design of a precise, holistic, and periodically measurable risk management framework. This prevention architecture should ideally encompass the elaboration of preventive elements based on anti-violence Standard Operating Procedures (SOPs), mandatory massive de-escalation training programs, the provision of sophisticated environmental security personnel and infrastructure, the design of victim-centered digital violence incident reporting systems, and, crucially, comprehensive rehabilitation and recovery procedures for every surviving staff member.

3.2. Legal Framework for Healthcare Workers’ Protection

The findings from the normative review indicate that Law Number 17 of 2023 concerning Health provides a strong and binding legal foundation for the protection of medical personnel and healthcare workers in the performance of their professional

duties. The law affirms state recognition of healthcare workers' rights to legal protection, particularly in ensuring occupational safety and security during service delivery. This protection is granted on the condition that healthcare professionals perform their duties in accordance with professional standards, ethical codes, and SOPs, with the primary objective of patient safety (O'Brien et al., 2024).

In the same breath, the 2023 Health Law reinforces healthcare workers' fundamental right to life safety and workplace security, shifting legal protection from a narrow, reactive concept (such as legal assistance in malpractice disputes) into a broader, systemic obligation requiring proactive institutional responsibility to ensure a violence-free and safe working environment (Effendy & Fikri, 2025; Olabisi et al., 2025). Accordingly, legal protection must be operationalized by the state and healthcare institutions through governance mechanisms that prevent physical, psychological, and structural threats, ensuring that healthcare workers can perform their duties under conditions of safety, dignity, and minimal occupational risk (Tamon et al., 2025).

When measured and viewed from afar using the perspective of administrative law science and the theory of hospital corporate governance policy instruments, this newly enacted proud conceptual norm academically harbors and engenders at least two chains of explanatory consequences that possess highly significant operational daily impacts (Effendy & Fikri, 2025). The first consequence emphasizes the reality that the nature of legal protection for every healthcare worker entity is actually designed with highly conditional characteristics. Meaning, the guarantee will only be activated if the absolute requirement of proof of consistent compliance with professional operational principles (including standard professional guidelines, clinical SOPs, and medical/nursing ethical codes) has been successfully met by the worker in question. The rational construction of this protection clause requirement essentially indirectly creates a very heavy imperative call demanding full commitment from top management operators of all hospitals indiscriminately in Indonesia.

They must radically intervene to ensure the availability of complete technical guide documents, continuous modernization, and most critically, perfect literacy comprehension levels of all relevant SOP manual document materials for all their hospital staff. This is because every inch of wording in the SOP narrative formulation in the eyes of the law has transformed its role from merely being a technical medical guide to crucially functioning as a primary measuring tool, a barometer of justice, and jurisprudence in court to assess and judge whether a series of actions taken by a healthcare worker in a certain critical situation are proven appropriate, reasonable, legally valid, and legally fulfill the prerequisites to execute the right to obtain the shield of legal protection or not. Thus, the noble goal of administering robust medical sector legal protection is a utopian discourse without first building the pillars of governance integrity regarding the formation, obedience, and compliance of the reporting audit system on every SOP itself (Effendy & Fikri, 2025).

The second explanatory consequence is the inclusion and formal recognition by the state of healthcare workers' rights regarding safety protection and freedom from threats of security instability in the workplace facility environment. This political and legal recognition has extraordinarily succeeded in maneuvering a shift in the epistemological discourse regarding the epidemic phenomenon of acts of violence against healthcare workers. It elevates the status of these cases from being narrowly viewed merely as "sociocultural personal conflict accidents" during working hours in the past decade, to a new, escalated status with maximum vigilance. These cases are now absolutely recognized and categorized into the catalog map of the serious threat hazard risk matrix over the integrity of healthcare facility operational institutional safety, which must fully become the domain of responsibility to be controlled, conquered, managerially solved, maturely budgeted, and fully

accountably managed by the hospital's management business operators. This confirms that violence against healthcare workers must be positioned as a formal occupational hazard requiring structural interventions such as zero-tolerance policies, risk assessments, environmental design, communication training, and clear reporting mechanisms as mandated by ILO/ICN/WHO/PSI guidelines (World Health Organization, 2002).

3.3. Protection Mechanisms and the Implementative Recommendation

Modelled based on the series of findings in the analysis above, the urgency of designing operational instruments is no longer negotiable. Genuine protection for healthcare worker groups requires us to transition from the phase of legal rhetoric to the institutionalization of protection (Effendy & Fikri, 2025). This article offers a mapping of procedures divided into two mutually reinforcing movement poles, namely: the activation of hospital internal mechanisms (as the primary line of defense and first curative measure), and the optimization of external assistance mechanisms (as repressive instruments).

At the level of internal mechanisms, the validity and effectiveness of legal protection guarantees must minimally rely on the establishment and consistent operation of four operational pillar constructs. The first pillar is the tangible existence of written, comprehensive mitigation prevention SOPs and violence handling protocols. These must include rigid descriptions defining the boundaries of physical violence incidents, verbal abuse, bullying, harassment, and non-physical/structural violence dimensions. This is combined with early warning criteria for incident risk indicators and detailed scenarios for rapid response command movements. The second pillar is the construction of a highly secure reporting system platform for emergencies and incident complaints. This channel must provide the optionality of identity-free reporting (anonymity) if urgently needed, must be guarded with anti-leak confidentiality protection oaths, accompanied by absolute anti-retaliation protection guarantees for the reporter and victim, and ensure the instrument is user-friendly and easily accessible to staff during distress (Tamon et al., 2025).

The third pillar involves the creation and establishment of standard protocols, guidelines, procedures, and mechanisms for internal due process. This includes the procedural framework for evidence gathering, investigation, fact-finding, and independent committee inquiries. This leads to the delegation of verdicts and the enforcement of administrative sanctions, disciplinary actions, or dismissals, executed with strict adherence to objective, fair, clear, and convincing standards of proof and legal procedures. The fourth pillar is the absolute obligation to provide resources, support programs, and rehabilitation packages for traumatized victims. This assistance spectrum must prioritize psychological counseling from forensic therapy specialists, legal advocacy support, and work adjustment facilitation (such as shift relaxation, rotation, or temporary leave) for victims demonstrating clinical signs of burnout or requiring a cooling-down period to prevent re-traumatization and emotional exhaustion (O'Brien et al., 2024).

Regarding the pursuit of justice through external enforcement mechanisms outside the hospital: If the anatomy of the violence aggression spectrum is convincingly proven to meet the qualification requirements of general criminal offenses (physical assault, serious threats of violence, defamation, or terror), taking the external legal route involving law enforcement, police investigators, and the justice system becomes a highly relevant, logical, and absolute alternative resolution option. Even when the violence is non-physical or structurally manifesting as psychological pressure or discriminatory management policies, external escalation channels remain constitutionally valid and open. These include reporting to and seeking advocacy from the Department of Manpower, health department inspectorates, the ombudsman, or relevant professional organizations, such as the

Indonesian Medical Association (*Ikatan Dokter Indonesia/IDI*) or the Indonesian National Nurses Association (*Persatuan Perawat Nasional Indonesia/PPNI*). The extent of their involvement will be flexibly tailored according to the specific escalation, complexity, and contextual details of the case (World Health Organization, 2002).

Based on an in-depth review of WHO–ILO guideline literature and empirical conditions in Indonesian hospitals, this study proposes a five-pillar recommendation model to strengthen workplace violence prevention and management in hospital governance (Jacobs & Porter, 1999). First, the establishment of a Zero Tolerance Policy formally endorsed by hospital leadership, publicly disseminated across all service units, and explicitly prohibiting physical, verbal, psychological, and discriminatory forms of violence, including bullying, threats, harassment, and biased employment practices. Second, the development of an integrated anti-retaliation reporting system that ensures safe, confidential, and 24-hour accessible digital reporting channels, enabling healthcare workers to report incidents without fear of retaliation while maintaining anonymity through secure system design.

Third, the implementation of smart risk assessment and safe facility design, particularly in high-risk areas such as emergency departments and psychiatric units. This includes periodic risk mapping, environmental redesign (such as secure access control, improved lighting, safe furniture layout), and emergency response tools such as panic alarm systems. Fourth, the provision of crisis communication and de-escalation training for clinical staff to equip them with skills in managing emotionally charged interactions, delivering difficult communication, and reducing escalation of conflict in high-pressure clinical settings. Fifth, the establishment of a victim recovery and psychosocial support system, including structured trauma counseling, legal assistance, workload adjustment, shift flexibility, and possible reassignment to support psychological recovery and reduce burnout. These five pillars emphasize a shift from reactive responses toward a proactive, system-based institutional strategy to ensure healthcare worker safety and reduce workplace violence in hospital environments (Tian et al., 2020; Ajuwa et al., 2024).

Through offering this tested and comprehensive governance recommendation model construct from the elaboration points above, this critical research has firmly placed the discourse of the narrative of commitment values and ideas regarding the protection of advocacy rights, legal guarantees, safety, and security not merely as an abstract theoretical framework, a rhetorical concept, or a philosophical fiction. Instead, it is positioned as a tangible blueprint, a concrete structural architecture, and operational policy guidelines that are strong, valid, and ready to be directly implemented, applied, and institutionalized into the organizational management system, operational bureaucracy, and the very lifeblood of the healthcare institution's governance (Tian et al., 2020).

4. Conclusion

This study concludes that legal protection for healthcare workers against workplace violence in Indonesia has been normatively strengthened through Law Number 17 of 2023 concerning Health, which guarantees the rights of medical and healthcare personnel to occupational safety, legal certainty, and professional protection while performing their duties according to professional standards and ethics. The study further confirms that workplace violence in healthcare should not be narrowly interpreted as isolated physical assaults, but must also include verbal abuse, psychological intimidation, bullying, and structural discrimination within hospital governance. Consequently, violence against healthcare workers must be recognized as a preventable occupational hazard requiring institutional accountability and systematic legal protection mechanisms.

The findings imply that hospitals, as healthcare institutions and employers, must operationalize legal norms into concrete governance mechanisms. These include zero-tolerance policies against violence, secure and anti-retaliation reporting systems, crisis communication training, integrated security protocols, psychological recovery services, and legal assistance for victims. Without effective institutional implementation, legal guarantees risk remaining symbolic and unable to provide substantive protection for healthcare workers.

Nevertheless, this research is limited by its normative juridical approach, which primarily focuses on legal interpretation and conceptual analysis without empirical field investigation into the implementation of violence prevention policies across Indonesian hospitals. Future research is therefore recommended to adopt empirical and socio-legal approaches by examining hospital compliance practices, reporting effectiveness, organizational culture, and healthcare workers' lived experiences regarding workplace violence. Comparative studies between public and private hospitals may also enrich understanding of institutional accountability and the practical effectiveness of legal protection mechanisms in Indonesia's healthcare sector.

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Ethical Approval and Originality Statement

Ethical approval was obtained for this study. The manuscript represents original work and has not been previously published, nor is it under consideration by another journal.

Data Disclosure Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.



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